TRICARE OTHER HEALTH INSURANCE (OHI) COVERAGE QUESTIONNAIRE

Do you or one of your family members currently have Other Health Insurance (OHI) coverage? YES NO

Have you or one of your family members had OHI during the past 12 months and recently cancelled or changed that coverage? YES NO
If you answered YES to either of the above questions, proceed to question #1.

IF YOU ANSWERED NO TO BOTH OF THE QUESTIONS LISTED ABOVE, DO NOT COMPLETE OR SUBMIT THIS FORM.

1. TRICARE Sponsor's Name:_____ **TRICARE Sponsor's SSN:**_____

2. CURRENT STATUS - Complete only if you or one or more of your family members currently have OHI.

Current OHI Status - I, or one of my family members, currently have other health insurance.

General Information

Does this coverage include pharmacy benefits? YES NO
Does this coverage provide any other benefits? YES NO
Does this coverage provide specific coverage exclusions? YES NO
(If yes, attach a copy of the exclusion page).

TYPE OF CURRENT OHI COVERAGE

Group Individual Supplemental Student plan Medicare Medicaid Other_____

Note: Complete one TRICARE OHI Coverage Questionnaire for each type of current OHI coverage.

3. PRIOR OHI STATUS - Complete only if you have had OHI within the last 12 months, but do not have the coverage now.

Prior OHI Status - I, or one of my family members, have had OHI during the past 12 months and have recently cancelled that coverage.

TYPE OF PRIOR OHI COVERAGE

Group Individual Supplemental Student plan Medicare Medicaid Other_____

Note: Complete one TRICARE OHI Coverage Questionnaire for each type of prior OHI coverage.

IF YOU HAVE COMPLETED SECTION 2 OR 3 ABOVE, please complete the following information, sign and submit to the address below.

	Name of Covered Member	Sex	Date of Birth	Carrier Name and Address	Policy/Group Plan #	Effective Date	Expiration Date (Applies for only Section 3)
Policyholder or Subscriber							
Other Family Members							

The statements made above are true and correct to the best of my knowledge. I understand that federal laws [8 U.S.C. and 100] provide for criminal penalties for submitting or making false, fictitious or fraudulent statements or claims in any matter within jurisdiction of any department or agency of the United States. I further understand that copies of the laws cited may be obtained from Uniformed Services legal offices, public libraries and many Health Benefit Advisors.

_____ _____ _____
Your Signature Relationship to TRICARE Sponsor Date

Please Note: Incomplete forms may result in a claims payment delay.

Please mail this form to: TRICARE - Region 3/4 ● Correspondence ● P.O. Box 7032 ● Camden, SC 29020-7032